# HEALTH SUMMARY
## Missouri FIRST STEPS Early Intervention System

Please complete this form to provide essential information from your perspective as this child's primary medical provider. Your participation is encouraged in order to ensure that appropriate medical information is available to assist in eligibility determination and service planning if the child is determined eligible. If you have questions, please contact the First Steps Intake Coordinator named on the cover letter. Your signature below indicates the accuracy and completeness of the information provided on this Summary. Thank you!

***Initial Health Summary*** ***Health Summary Update***

***IDENTIFYING INFORMATION***

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

***MEDICAL INFORMATION (For Initial Health Summary Only)***

Reason(s) for Referral: _____

Birth Place: _____ Birth Weight: _____ grams _____ lbs/oz Gestational Age: _____

Length of Hospital Stay: _____

***CURRENT HEALTH STATUS***

Present concerns/diagnosis*/illnesses: (*ICD-9 CODE: _____) _____

Hospitalizations/Surgeries: _____

Current Medications: _____

Medical Precautions: _____

Immunizations are up to date: ? YES ? NO Date you last saw this child:_____

Physical Status: _____

Vision Status: _____ Hearing Status: _____ Developmental Status: _____

Date Screened/Tested: _____ Date Screened/ Tested:_____ Date Screened/ Tested: _____

Results: _____ Results: _____ Results: _____

Other Referrals Made: _____

***ADDITIONAL COMMENTS***. Attach additional pages if necessary.

***Signature:*** _____ ***Date:*** _____ ***Name:*** _____

***Primary Care Provider or Designated Representative***

PCP#_____ Address: _____

Telephone:_____ FAX: _____

March 03